there are established agencies that evaluate new pharmaceuticals to inform health care policy decisions (e.g., the HAS in France and NICE in the UK). This analysis will consider the strengths and weaknesses of European health technology bodies (HTA) and provide insight for the implementation of CER and how lessons learned from the UK and France might help improve efficiency and outcomes in oncology in the US. **METHODS:** Secondary research will be used to review how HTA bodies evaluate oncologics and assess their impact on market access. These countries were selected as they represent the extremes of HTA assessment in Europe. Findings from this research will then be contrasted against current market access in the US. **RESULTS:** While France evaluates new products on innovation and clinical value the UK largely bases market access decisions on cost-effectiveness. Consequently, many new oncology agents available in France have been denied funding in the UK. Meanwhile, insured Americans have relatively open access. **CONCLUSIONS:** Cancer remains the second leading cause of death in the US and is a growing health care burden. Therefore better informed policy decisions on the efficient use of clinical services for oncology are critical. This analysis suggests that there is potential for the US to optimize on the European experiences when considering the adoption of a CER tool for oncology drugs management. Specifically, if the US does adopt a formal CER entity, it may wish to avoid using NICE-like economic-based outcomes to change clinical practice, but and aim to play an advisory role to facilitate better informed strategic decisions (HAS-like).

PCN143

COST-EFFECTIVENESS OBSERVATIONS AND ONCOLOGY DRUG REIMBURSEMENT RECOMMENDATIONS IN CANADA BY THE JOINT ONCOLOGY DRUG REVIEW

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OBJECTIVES: In Canada, the interim Joint Oncology Drug Review (JODR) conducts health technology assessments for all oncology products and provides funding recommendations to participating provinces. Summaries of these recommendations are publically available, however investigation of the potential factors that influence these decisions has not been conducted. Furthermore, the acceptable incremental cost-effectiveness ratio (ICER) used by the JODR has not been published. This analysis was conducted to assess the differences in the average ICER between the JODR's positive and negative recommendations and determine the relative influence of cost-effectiveness evidence on decision-making. **METHODS:** A literature search for pharmacoeconomic data was conducted for all 24 drugs with cancer indications reviewed by the JODR and made publicly available between March 2007 and December 2009. Cost-effectiveness data was extracted and converted into Canadian currency (CAD) to provide an estimate for Canadian public payers. The JODR and Ontario Public Drug Plan (OPDP) recommendations and decisions were analyzed in the context of these ICER values. **RESULTS:** Cost-effectiveness literature was found for 18 of the 24 drugs and of those, only 15 had published ICER values. ICER values ranged from approximately CAD$10,000/QALY to CAD$127,000/QALY. The average ICER of those cancer drugs considered to be cost-effective by the JODR was CAD$44,269/QALY, whereas the ICER for drugs considered not cost-effective was CAD$75,882/QALY ($p = 0.10$). Furthermore, drugs that were recommended for funding had a lower ICER when compared to those that were not recommended for funding ($57,578 vs. $81,490/QALY, $p = 0.50$). **CONCLUSIONS:** These findings suggest that while the ICER may be an important factor in the JODR decision-making process, a careful examination of all factors leading to final reimbursement decisions is needed to fully understand the relative importance of the ICER. Further research is required to determine if there are differences in the application of the ICER in decision-making processes for oncology medications versus other disease areas.

PCN144

COMPARITIVE KNOWLEDGE OF BREAST SELF EXAMINATION IN MIDWIFERY AND NURSING STUDENTS IN ISLAMIC AZAD UNIVERSITY KARAJ BRANCH

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BACKGROUND: Breast cancer is the most common type of cancer among women world wide ranking second in mortality from cancer. Bse is a screaning method that should be taught at an early age so as to educate women about the importance of early detection of breast cancer. **OBJECTIVES:** The aim of this study was to evaluate the level of knowledge of midwifery and nursing student regarding breast self –examination . **METHODS:** This study is descriptive on 23 midwifery and 69 nursing student.data collection tool was a questionnaire the included6 questions about demographic characteristics, and 14 question about knowledge breast self examination. Data analyzed by descriptive statistics. **RESULTS:** Our results show that the average age being (21–35),majo rity of them are single (%67/4)and (%29/3) twin. Our result showed no significant differences in midwifery and nursing knowledge.($p > 5\%$). Our result showed the students of midwifery and nursing have mild knowledge. **CONCLUSIONS:** It seems that despite of the importance of the BSE in early diagnosis of breast cancer the majority of women have poor knowledge and practice about BSE.Based on the positive attitude of most women about BSE, it is that increasing the knowledge of women by education ways of breast cancer, especially BSE, this will be available by more attention of public health centers, TV and newspaper for increasing women awareness. Key word:breast,student,cancer,self examination.

PCN145

A COMPARISON OF PHYSICIAN AND PATIENT DECISION MAKING FOR FIRST VERSUS SECOND OPINIONS AMONG MEN WITH LOCAL STAGE PROSTATE CANCER

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OBJECTIVES: Expert groups recommend men with local stage prostate cancer seek second opinions before choosing a management option. The nature of the physician-patient interaction and outcomes for second versus primary opinion visits are unknown. **METHODS:** Newly diagnosed local stage prostate cancer patients and physicians at urology practices in three states participated in a survey of patient and doctor decision making following biopsy but prior to initiating treatment. Physicians were asked about the clinical status of the patient's cancer, treatments discussed and recommended, and what factors most influenced the physician's treatment recommendation(s). Patients were asked their treatment preference and what treatments the physician recommended. **RESULTS:** A total of 238 local stage prostate cancer patients and their urologists completed surveys. Patient characteristics were: 47% aged 60–69; 71% white, 16% black, 11% Hispanic; 49% had an income of ≥$75,000. Ninety-five men were presenting for a primary consultation; 143 men were presenting for a second opinion. Among the initial consultation group, 64% were considering/planning a prostatectomy. Among the group seeking a second opinion, 83% were considering/planning a prostatectomy. Of those seeking a primary recommendation 59% had low risk disease, similar to the second opinion setting (54%). For low risk patients (primary vs. secondary opinions, respectively), physicians recommended surgery for 80%/90%, external radiation for 38%/16%, seeds for 52%/14%, and watchful waiting for 25%/16%. In multivariate analysis, during an initial consultation physicians recommended 0.51 more treatments (standard error 0.12, $p < 0.001$) and were half as likely to consider the patient's preference as a factor in their recommendations (OR 0.49, CI 026–0.95). **CONCLUSIONS:** Patient preferences and physician recommendations differ substantially in secondary versus primary opinion settings. In secondary opinion visits, patients are more likely to want prostatectomy and physicians are more likely to consider patient preference when making recommendations. This is true even for men with low risk disease.

PCN146

REAL WORLD DATA ON MULTIPLE MYELOMA (MM) TREATMENT IN BRAZIL: GUIDANCE FOR THE PRIVATE HEALTH CARE SYSTEM (PHS)

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OBJECTIVES: New treatments in oncology frequently imply in higher costs. Historically there is a lack of statistical data on cancer treatments in PHS in Brazil. Higher costs combined to lack of information may result in waste of resources. We present here real world data (RWD) on MM treatment collected from a dedicated database of cancer treatments Evidencias® (www.evidencias.com.br). **METHODS:** Between November of 2007 and October 2009 we retrieved all patients with MM registered on Evidencias®. Anthropometric data, staging, types of treatment, duration, and cost of chemotherapy and adjunctive therapies (AT) such as antiemetics, erythropoietin, colony stimulating factors and bisphosphonates were extracted. **RESULTS:** We identified 98 patients (53% women and 47% men). The mean body surface area (BSA) was1.73 m^2. Staging was stratified as follows: 21% Stage I, 8% stage II and 54% stage III. In 17% of the cases stage information was unavailable. Total cost of drugs was US$1,709,404.50. Chemotherapy drugs represented US$1,214,275.03 (71%) of which 98% (US$1,192,849.98) were due to the use of Bortezomib and 29% (US$495,129.46) to AT. Bortezomib was present in 57% of the treatments either isolated (42%) or combined to other chemotherapy (15%). Cyclophosphamide was used in 20% of the treatments, Doxorubicin in 18% and Melphalan in 5%. Mean duration of treatment was 3.9 cycles of chemotherapy. **CONCLUSIONS:** Real world data although a fundamental tool to guide health care providers in the correct allocation of resources, is still rare in Brazil e Latin America. Bortezomib is used in 57% of MM treatments but represents 98% of chemotherapy costs.

PCN147

CHARACTERISTICS OF POSTMENOPAUSAL WOMEN INITIATING RALOXIFENE BEFORE AND AFTER APPROVAL OF INVASIVE BREAST CANCER RISK REDUCTION INDICATIONS

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OBJECTIVES: This study evaluated characteristics of postmenopausal women (PMW) who initiated raloxifene (RLX) therapy before and after the approval of the invasive breast cancer (BC) risk reduction (IBCRR) indications. **METHODS:** PMW 50 years and older with at least one claim for RLX in 2005–2008 and continuous enrollment over the study period (Jan 2004-Dec 2008) were identified in a large national commercial and Medicare supplemental claims database. PMW on RLX were evaluated based on clinical and demographic variables such as age, provider specialty, fractures, bone mineral density (BMD) screening, Chronic Disease Score (CDS), family history of BC, and mammograms 12 months before and 12 months after the IBCRR indication